

FOOD STAMP NOTICE OF CHANGE

COUNTY OF _____

STATE OF CALIFORNIA
HEALTH AND HUMAN SERVICES AGENCY
CALIFORNIA DEPARTMENT OF SOCIAL SERVICES

Notice Date : _____
Case Name : _____
Number : _____
Worker Name : _____
Number : _____
Telephone : _____
Address : _____

(ADDRESSEE)

If you have any questions or want more information about this action, please contact your worker.

State Hearing: You can ask for a hearing if you believe the action is wrong. The back of this page tells how to ask for a hearing. If you already had a hearing on the cause of the overissuance that is being collected, you cannot ask for a new hearing, unless you think the new amount of food stamps you are getting because of the overissuance collection is incorrect.

☐ **CHANGE IN BENEFITS.**

Effective _____, your food stamp benefits are changed from \$ _____ to \$ _____ each month because:

- ☐ You have already been told about an overissuance of food stamps and you are getting less food stamps because the County has been reducing your monthly allotment by 10% or \$10 (whichever is more) to pay back the food stamps that you got and should not have. It has been decided in court or by a state hearing or because you signed a Disqualification Consent Agreement or an Administrative Disqualification Hearing Waiver that this overissuance is an Intentional Program Violation (IPV). Now your monthly allotment is being changed because the County can begin reducing your allotment by 20% or \$10 (whichever is more). If there are any other changes to your monthly food stamp allotment, this form will tell you.

☐ **SUSPENSION.**

Effective _____, your food stamp benefits are suspended because:

You will not receive any food stamp benefits for _____.

During this period of suspension, you must continue to complete and submit your monthly report (CA 7) so we can determine if you will be eligible for benefits the month after the month of suspension. If you do not submit a complete CA 7 during the month of suspension, your food stamp participation will be terminated.

Rules: These rules apply to the above action(s):

You may review them at your welfare office.

☐ **TERMINATION.**

Effective _____, your food stamp benefits are terminated because:

- ☐ Based on the reason your benefits are terminated, your household is also disqualified from participating in the Food Stamp Program until _____. You may reapply for benefits at the end of this disqualification period.

☐ **PROPOSED CHANGE IN BENEFITS.**

Effective _____, your food stamp benefits may be reduced or terminated because information needed to determine your continued eligibility or the correct amount of your benefits was not received with your monthly report (CA 7). We must receive the following information by no later than the first day of next month:

If verification of an expense is requested and you do not provide it, the expense will not be allowed when computing next month's benefits. Also, if you do not provide other requested information, your benefits may be reduced or terminated.